DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE HEALTH CENTER	932 BADDOUR PARKWAY LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 03/27/2017. During this Life Safety Survey, Quality Health Center was found not in substancial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K211 Means of Egress – General **Corrective Action:** The Miscellaneous storage obstructing egress was removed by the Director of Maintenance and staff was Inserviced by ADM or designee on keeping egress unobstructed and clear of storage. The kitchen emergency exit egress step had a secondary concrete step added to meet exit requirements by the Director of Maintenance. **Identifying other residents with potential to be affected:** The facility determined there were no residents that have the potential to be affected as there are no residents that exit from the kitchen. However, other egress areas in the facility have the potential to affect other residents if the egresses are obstructed. The exit doors in the facility will be checked by the ADM or designee for appropriate egress for the purpose of identifying other potential obstructed egresses affecting resident's safety. Other exit egress steps will be checked by the ADM or designee for the purpose of ensuring they meet exit requirements. **Measures or Systemic Changes:** The miscellaneous storage obstructing the kitchen exit door has been relocated to another area in the kitchen and a sign has been posted indicating no storage allowed to obstruct egress by the Director of Maintenance. The exit door area will be added to the Kitchen Sanitation checks to be performed by the Director of Dietary or designee. A secondary step was added to the kitchen egress to meet the exit requirements by the Director of Maintenance. **How corrective action will be monitored:** The exit door will be checked by the ADM or designee 1x week x 4 weeks and then monthly x 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 211 SS=D	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the exits. The findings included: 1. Observation on 03/27/2017 at 10:01 AM, revealed the kitchen emergency egress door was obstructed by misc. storage. NFPA 101, 19.2.1 (2012 Edition) NFPA 101, 7.1.10.1 (2012 Edition) 2. Observation on 03/27/2017 at 10:04 AM, revealed the step outside the kitchen emergency	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne Battle | TITLE: Administrator | (X6) DATE: 4/19/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 211	Continued From page 1 egress door exceeded the maximum riser height for a step in the means of egress. NFPA 101, 19.2.1 (2012 Edition) NFPA 101, 7.2.2.2.1.1 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 211	K222 – Egress Doors **Corrective Action:** The padlock to the outside green gate was removed by the Director of Maintenance and the staff was inserviced by the ADM or designee on the need and requirement for no double lock on egresses and power magnetic locks must release upon activation of the fire alarm system. The 2 doors beside the South 1&2 nurse station were repaired by contractor to release upon fire alarm activation.	4/27/17
K 222 SS=F	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is	K 222	**Identifying other residents with potential to be affected:** The facility determined that any residents utilizing the courtyards one either side of the gate with pad lock would have the potential to be affected and any residents in or around the South I & II nurses station or on the unit halls would have the potential to be affected. Gates were checked by the Director of Maintenance for the purposes of ensuring no double locking mechanisms were present. Exit doors were tested by the Director of Maintenance during fire alarm activation for the purpose of ensuring the power magnetic locks released upon activation. **Measures or Systemic Changes:** The pad lock on the green gate was removed by the Director of Maintenance and checking gates for double locking mechanisms will be added to the Maintenance Checklist to be performed by the Director of Maintenance or designee. Testing the power magnetic lock doors will be added to the fire drill procedures to be performed by the Director of Maintenance or designee. **How corrective action will be monitored:** The gates will be checked by the ADM or designee 1x week x 4 weeks then monthly for 2 months. The doors with magnetic power locks will be checked by the ADM or designee 1x month x 3 months. The ADM or designed will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	

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K 222	Continued From page 2 constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the egress doors. The finding included: 1. Observation on 3/27/17 at 9:40 AM, revealed an outside gate (green) leading out of the smoking area padlocked with no key. NFPA 101,	K 222		

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K 222	Continued From page 3 19.2.1 (2012 Edition) NFPA 101, 7.2.1.5.3 (2012 Edition) 2. Observation and testing during the fire drill on 3/27/17 at 11:51 AM, revealed the magnetic power locks (2 of 2) did not release on fire alarm activation located beside the South 1&2 nurse station. NFPA 101, 19.2.1 (2012 Edition) NFPA 101, 7.2.1.6.1 (2012 Edition) The maintenance director was present when this deficiency was identified and was acknowledged by the administrator during the exit conference on 3/27/17.	K 222		
K 293 SS=D	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the exit signage. The finding included: Observation on 03/27/2017 at 10:55 AM, revealed the exit sign located at the cross corridor door by room 55, south nurses station and by the conference room did not direct towards the nearest exit. NFPA 101, 19.2.10.1 (2012 Edition) NFPA 101, 7.10.6.2.1 (2012 Edition)	K 293	K293 - Exit Signage **Corrective action:** The exit sign located at the cross corridor door by room 55, south nurse station and by the conference room were corrected by the Director of Maintenance to direct towards the nearest exit. The staff was inserviced by the ADM or designee regarding exit signs must direct towards nearest exit. **Identifying other residents with potential to be affected:** The facility determined that any residents in the exit path near or around the corridor by room 55, south nurse station and the conference room have the potential to be affected. Exit signs were checked by the Director of Maintenance for the purpose of ensuring the signs direct towards the nearest exit. **Measures or Systemic changes:** Checking exit signs for direction towards nearest exit will be added to the Maintenance Checklist to be performed by the Director of Maintenance or designee. **How corrective action will be monitored:** The exit signs will be checked monthly by the ADM or designee. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17

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K 293	Continued From page 4 Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 293	K321 – Hazardous Areas – Enclosure **Corrective action:** The penetration around the 8" metal exhaust vent in the boiler room was sealed using the appropriate fire stopping system by the Director of Maintenance under the supervision of a consultant certified in fire stop systems. The laundry door was repaired by Director of Maintenance and contractor by adjusting the self-closing device as well as adding spring hinges. The staff was inserviced by the ADM or designee regarding fire penetrations and the need for the laundry door to close properly. **Identifying other residents with potential to be affected:** The facility determined that all residents have the potential to be affected. Other boiler rooms and mechanical rooms will be checked by the Director of Maintenance or designee and any identified penetration sealed with the appropriate fire stopping system under the supervision of a consultant certified in fire stop systems. Fire/Smoke doors will be checked by the Director of Maintenance for required closure and any issues identified will be repaired by the Director of Maintenance or designee. **Measures or Systemic Changes:** Looking for fire penetrations will be added to the Maintenance Checklist to be performed by the Director of Maintenance or designee as well as checking fire doors for the required closure. **How corrective action will be monitored:** The boiler rooms and mechanical rooms will be checked by the ADM or designee 1x week x 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report the findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation the facility failed to	K 321		

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K 321	Continued From page 5 maintain hazardous areas. The findings included: 1. Observation on 03/27/2017 at 10:40 AM, revealed a penetration around an 8" metal exhaust vent in the boiler room behind central supply. NFPA 101, 8.3.5 (2012 Edition) 2. Observation on 3/27/17 at 1:00 PM, revealed the commercial laundry door (washer side) did not self close within the frame. NFPA 101, 19.3.2.1.3 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 321		
K 324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2; 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324	K324 – Cooking Facilities **Corrective action:** The rooftop hood shaft grate has been removed by contractor and the rooftop exhaust hood cover has been secured properly to the assembly by the Director of Maintenance. **Identifying other residents with potential to be affected:** The facility determined that all residents have the potential to be affected, however, there is no other potential areas to be affected with grease build up as there is only 1 kitchen hood. **Measures or Systemic changes:** Checking the kitchen hood for grease build up and the hood cover securement will be added to the Maintenance Checklist to be performed by the Director of Maintenance or designee. **How corrective action will be monitored:** The hood and the hood cover will be check by the ADM or desginee 1x week x 4 weeks and then monthly for 2 months. The ADM or designee will review the audits and report the findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17

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K 324	Continued From page 6 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observations, the facility failed to protect the cooking equipment. The findings included: 1. Observation on 3/27/17 at 11:36 AM, revealed excessive grease buildup on the rooftop hood shaft grate. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 101, 9.2.3 (2012 Edition) NFPA 96, 11.6.2* (2012 Edition) 2. Observation on 3/27/17 at 11:39 AM, revealed the rooftop exhaust hood cover was not secured properly to the assembly. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 101, 9.2.3 (2012 Edition) NFPA 96, 11.5 (2012 Edition) The maintenance director was present when these deficiencies were identified and the administrator later acknowledged these deficiencies during the exit conference on 3/27/17.	K 324		
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		

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K 345	Continued From page 7 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoke detectors. The finding included: Observation on 3/27/17 at 9:11 AM- 10:00AM, revealed smoke detectors within three (3) feet of airflow in the following locations: a. corridor by the conference room b. A&B clock in room c. corridor behind administrators office. NFPA 101, 19.3.4.5.1 (2012 Edition) NFPA 101, 9.6.1.3 (2012 Edition) NFPA 72, 17.7.4.1 (2012 Edition) The maintenance director was present when this deficiency was identified and was acknowledged by the administrator during the exit conference on 3/27/17.	K 345	K345 – Fire Alarm System – Testing / Maintenance **Corrective action:** The smoke detectors in the corridor by the conference room, A&B clock room and corridor behind Administrative offices have been moved by contractor to an area outside of 3 feet of air flow. **Identifying other residents with potential to be affected:** The facility determined that any residents near or around smoke detectors that are not outside of 3 feet from air flow have the potential to be affected. Smoke detectors will be checked by the Director of Maintenance to ensure they are not within 3 feet of air flow. Any additional smoke detectors identified within 3 feet of air flow will be moved by contractor. **Measures or Systemic changes:** Any smoke detectors found to be within 3 feet of air flow will be moved by contractor. **How corrective action will be monitored:** The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		

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K 353	Continued From page 8 maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. The findings included: 1. Observation on 03/27/2017 at 10:05 AM, revealed a downward pendant sprinkler installed in the sidewall position in the ICF kitchen outside storage closet. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.1.1 (2012 Edition) NFPA 13, 8.3.1.1 (2010 Edition) 2. Observation on 03/27/2017 at 10:33 AM, revealed storage of cardboard boxes under the canopy outside of the exit across from the Physical Therapy gym without sprinkler coverage. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.1.1 (2012 Edition) NFPA 13, 8.15.7.5 (2010 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 353	K353 – Sprinkler System – Maintenance / Testing **Corrective Action:** The downward sprinkler head in the sidewall of the ICF kitchen closet has been replaced by a contractor with an appropriate sprinkler head. The cardboard boxes under the canopy outside of the exit across from Physical Therapy have been removed by the Director of Maintenance. Staff was inserviced by ADM or designee on not storing under the canopy area. **Identifying other residents with potential to be affected:** The facility determined that no residents had the potential to be affected by the sprinkler head in the outside kitchen storage room and any residents near or around the canopy area outside the exit across from Physical Therapy or any residents outside under the canopy area have the potential to be affected. Sprinkler heads in closets will be checked by the Director of Maintenance or designee for appropriate heads. The canopy area will be checked for storage and a sign posted by the ADM or designee indicating there is no storage allowed in that area. **Measures or Systemic changes:** Any sprinkler heads identified to be the incorrect type will be replaced by contractor with the appropriate type. Checking the canopy area will be added to the Maintenance Checklist to be performed by the Director of Maintenance or designee. **How corrective action will be monitored:** The canopy area will be checked by the ADM or designee 1x week x 4 weeks and then monthly for 2 months. The ADM or designee will review audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 355	NFPA 101 Portable Fire Extinguishers	K 355		

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445154	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/27/2017

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K 355 SS=D	Continued From page 9 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the fire extinguishers. The findings included: Observation on 03/27/2017 at 10:03 AM, revealed the no Class K fire extinguisher placard posted at the Class K extinguisher (sign posted over the ABC extinguisher on a different wall). NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.4.1 (2012 Edition) NFPA 10, 5.5.5.3 (2010 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 355	K355 – Portable Fire Extinguishers **Corrective Action:** The Class K fire extinguisher sign has been moved by the Director of Maintenance to the location of the extinguisher. Staff inserviced by ADM or designee on location of extinguisher. **Identifying other residents that have the potential to be affected:** The facility determined that any residents near or around the kitchen have the potential to be affected as residents are not in the kitchen. There is no other potential area to be affected by Class K fire extinguisher as there is only 1 in the facility, located in the kitchen. **Measures and Systemic changes:** The sign indicating the location of the Class K Fire extinguisher was moved by the Director of Maintenance to the location of the extinguisher. **How corrective action will be monitored:** The location of the sign will be checked by the ADM or designee 1x month x 3 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the	K 363		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2017
FORM APPROVED
OMB NO. 0938-0391

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K 363	Continued From page 10 doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain corridor doors. The findings included: Observation on 03/27/2017 at 11:27 AM, revealed the corridor door of the ICF kitchen dishwashing room did not resist the passage of smoke (gap at the top of the door over ½ inch). NFPA 101, 19.3.6.3.2 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 363	K363 – Corridor – Doors **Corrective Action:** The corridor door of the ICF kitchen dishwashing room has been repaired by the Director of Maintenance and no longer has gap greater than ¼ inch to meet the resistance of the passage of smoke. Staff was inserviced by the ADM or designee on checking smoke/fire doors. **Identifying other residents who have the potential to be affected:** The facility has determined that any residents near or around the ICF kitchen dishwashing room have the potential to be affected. Smoke doors will be checked by the Director of Maintenance or designee for the purpose of ensuring there is not a gap greater than 1/2 ". **Measures or Systemic changes:** Checking smoke doors was added to the Maintenance Checklist to be performed by the Director of Maintenance or designee and any doors identified with a gap greater than 1/2 " will be repaired by Director of Maintenance or designee. **How corrective action will be monitored:** Smoke/Fire doors will be checked by the ADM or designee monthly x 3 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 364 K 364 SS=D	Continued From page 11 NFPA 101 Corridor - Openings Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the corridor openings. The finding included: Observation on 3/27/17 at 10:18 AM, revealed a transfer grill in the A-B shower room and ice machine room. NFPA 101, 19.3.6.4.1 (2012 Edition) The maintenance director was present when this deficiency was identified and was acknowledged by the administrator during the exit conference on 3/27/17.	K 364 K 364	K364 – Corridor Openings **Corrective Action:** The doors with transfer grills located at A-B shower room and ice machine room have been repaired by the Director of Maintenance and no longer contain a transfer grill. **Identifying other residents who have the potential to be affected:** The facility determined that any residents in, near or around the A/B shower room have the potential to be affected. Facility doors will be checked by the Director of Maintenance or designee for transfer grills. **Measures or Systemic Changes:** Any doors identified with transfer grills will be repaired by the Director of Maintenance or designee. **How corrective action will be monitored:** The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric	K 511		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 511	Continued From page 12 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the utilities The findings included: 1. Observation on 03/27/2017 between 10:13 AM and 10:26 AM, revealed the junction boxes in the corridor (fire alarm indicating devices) were not installed properly (partially recessed in the wall) in the following locations: a. Outside room 103 b. Outside room 99 c. Outside room 111 NFPA 101, 19.5.1.1 (2012 Edition) NFPA 101, 9.1.2 (2012 Edition) NFPA 70, 314.20 (2011 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 511	K511 – Utilities – Gas and Electric **Corrective Action:** The junction boxes outside rooms 103, 99 and 111 have been repaired and are recessed in the wall by a contractor. **Identifying other residents who have the potential to be affected:** The facility determined that all residents have the potential to be affected. Junction boxes will be checked by the Director of Maintenance or designee to ensure they are completely recessed in the wall. **Measures or Systemic Changes:** Any junction boxes identified not completely recessed in the wall will be repaired by Director of Maintenance or designee or contractor if warranted. **How corrective action will be monitored:** The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:	K 741		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 741	Continued From page 13 (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to enforce smoking regulations. The finding included: Observation on 3/27/17 at 11:01 AM, revealed an employee smoking in a non designated smoking area (out back behind central supply). The maintenance director was present when this deficiency was identified and was acknowledged by the administrator during the exit conference.	K 741	K741 - Smoking Regulations **Corrective Action:** Employee was counseled about smoking in a non-smoking area by ADM. Staff were inserviced by ADM or designee that smoking is only permitted in designated areas. **Identifying other residents that have the potential to be affected:** The facility determined that any residents safe to go outside near the area in question would have the potential to be affected. Areas with flammable liquids, combustible gases, oxygen in use or stored and any other hazardous location will be checked by the Director of Maintenance or designee to ensure there are No Smoking signs posted. **Measures and Systemic Changes:** Areas where any flammable liquids, combustible gases, oxygen in use or stored and any other hazardous locations without a No Smoking sign will be posted by the Director of Maintenance or designee. **How corrective action will be measured:** The non-smoking area behind central supply will be monitored by ADM or designee 1x week x4 weeks then monthly for 2 months. The ADM or designee will review audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17
K 923	NFPA 101 Gas Equipment - Cylinder and	K 923		

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K 923 SS=E	Continued From page 14 Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by:	K 923	K923 – Gas Equip – Cylinder and Container Storage **Corrective Action:** The ICF oxygen storage has been relocated by the Director of Maintenance from the room with the plastic cart and wood counter and the Oxygen sign was removed by the Director of Maintenance. The Skilled Unit oxygen room had concentrators removed by the Director of Maintenance. Staff was inserviced by ADM or designee on proper storage of oxygen. A sign indicated no combustible materials, including concentrators, was posted in the oxygen storage room by the ADM or designee. **Identifying other residents having the potential to be affected:** The facility determined that any residents near or around the ICF and Skilled units have the potential to be affected. Facility Oxygen storage rooms will be checked by the Director of Maintenance or designee for proper storage. **Measures and Systemic Changes:** Any Oxygen storage room found with combustible materials will have the combustible materials removed or the oxygen storage relocated to a proper storage room by the Director of Maintenance or designee. O2 rooms will have signs posted by the ADM or designee indicating no combustible materials, including concentrators. **How corrective action will be monitored:** Oxygen storage rooms will be checked by ADM or designee 1x week x 4 weeks then monthly for 2 months. The ADM or designee will review audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	4/27/17

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K 923	Continued From page 15 Based on observations, the facility failed to maintain the oxygen storage areas. The findings included: Observation on 03/27/2017 between 9:46 AM and 10:18 AM, revealed the oxygen storage within 5 feet of combustible materials in the following locations: a. ICF oxygen storage room 28 "E" cylinders (plastic cart and wood counter) b. Skilled Unit oxygen storage room (oxygen concentrators) NFPA 99, 11.3.2.3 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 03/27/2017.	K 923		